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ABSTRACT

Recognizing the need for a health manpower planning system that would insure the recruitment, training, utilization, and retention of area residents as skilled providers of health care, Comprehensive Health Planning, Inc., Metropolitan Chicago (CHP), and the West Side Health Planning Organization (WSHPO) embarked on a 1-year project to demonstrate the feasibility of Health Manpower Planning. The project concentrated on the allied health fields, establishing a two-phase work program of data gathering and project implementation. Twelve cooperative goals were established and methods and procedures determined. Major areas of concern were: (1) utilization and attrition, (2) hospital training programs, (3) college level education programs, and (4) counseling and recruitment. Two major barriers to effective planning were a need for further cooperation between health care facilities and academic institutions, and educating the community to the opportunities in the health fields. Two conferences addressed these problems, and 10 recommendations for further cooperative planning were outlined. Four new programs growing out of this project are described to demonstrate the need for a coordinating agency in a comprehensive health care delivery system. An 80-page appendix offers survey instruments and five project working papers. (JC)

ED 095354

Comprehensive Health Planning, Inc.
Metropolitan Chicago

STUDY OF THE SUBAREA APPROACH TO HEALTH MANPOWER PLANNING

Contract No. NIH-72-4324

Bureau of Health Manpower Education
Bethesda, Maryland

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PROJECT REPORT NARRATIVE

Rationale for Project Development

The current state of the labor market is causing much concern among those individuals and institutions whose commitment is to provide employment opportunities. As a result of increased technology there are very few jobs in the private or public sector, except in those areas which require highly skilled individuals who can handle technical assignments. Further technology has provided industry with the capability to produce far more goods and services than the public is demanding. This leaves those individuals who have few tangible skills and are out of work little option as to the kind of employment they can seek and realistically expect to find. Many manpower experts, economists and labor leaders feel that in order to alleviate the critical shortage of employment opportunities there must be a new approach to manpower development, and a system developed which provides not only jobs, but careers as well. Since the private sector is so depressed, the most logical place to look is to the public sector, especially in the area of the human services where there is tremendous need for trained personnel.

The fast growing health industry provides an excellent opportunity for the development for new and meaningful careers which could provide challenging work for many unemployed or marginally employed individuals, decrease the welfare roles, stimulate the economy and make possible the availability and accessibility of good health services to a larger percentage of the population. The development of careers in health or health related areas is perhaps more ideal than in some of the other human service areas because needs can be more clearly defined and results more clearly seen.

It has been agreed that one of the most acute health care needs of Chicago's west side is the conceptualization, design, development and implementation of a health manpower planning system that will assure provision of the necessary medical and allied health manpower for the development and implementation of an optimal health care delivery system for the area. Inherent in that system should be a mechanism or mechanisms that will insure the recruitment, training, utilization and retention of area residents as skilled providers of care. Recognizing this need, in December of 1971, the Comprehensive Health Planning, Inc., Metropolitan Chicago (CHP), through an agreement with the Human Services Manpower Career Center, made provisions for the West Side Health Planning Organization (WSHPO) to utilize the services of a health manpower planner as a supplement to its other activities. This arrangement proved to be most beneficial to WSHPO, for in a short period of time it has developed a plan of action for health manpower planning.

In July of 1972, the WSHPO and CHP, with funding assistance from the National Institutes of Health, Bureau of Health Manpower, embarked upon a project to demonstrate the feasibility of Health Manpower Planning, using the CHP sub-area approach. This approach consists of dividing a large urban area (in this case metropolitan Chicago), into smaller parts that more closely reflect varying community characteristics and health needs and focusing planning efforts upon the geographic units thus established.

The project specifically called for CHP and WSHPO to cooperatively:

1. Study present attrition and turnover rates in health fields in the sub-area.

2. Develop programs which reduce such attrition and turnover rates.

3. Determine the location of existing training programs, evaluate them and work to make them more accessible to the local community.

4. Study the nature and extent of student interest in the health field and analyze the relative effectiveness of the many recruitment mechanisms now in use as well as make suggestions for future mechanisms.

5. Study and develop programs for recruitment and counseling of presently underdeveloped sources of manpower such as the economically and educationally deprived ex-corpsmen, prisoners, and the handicapped.

6. Develop tutorial programs to enable the disadvantaged to pursue health careers that will help meet needs in manpower shortage areas.

7. Develop methods to relate all training to community health needs.

8. Develop methods for maintaining awareness of licensure activities, personnel requirements, etc.

9. Develop a system of coordinated recruitment and referral for positions in sub-area health occupations training programs.

10. Develop such task forces or committees as may be necessary to carry out the above purposes. Members of such groups shall be chosen on the basis of their interest in west side health manpower problems, demonstrated competency in a health or educational field, and ability to devote time to participation in such groups as may be established.

11. Utilize the information resources of other city and state health planning organization -- such as the Health Education Commission of the State of Illinois and the Health Careers Council of Illinois -- as a data base for conducting program activities.

12. Within 12 months after project inception, CHP shall study health manpower problems in other sub-areas of the city, evaluate existing manpower planning and program functions, and develop a coordinating mechanism to relate all sub-area programs in metropolitan Chicago.

Methods and Procedures

Methodology:

The joint CHP-WSHPO Manpower Project was designed to build and develop the process begun through the activities of the manpower planner made available to WSHPO through an agreement between CHP and the Human Services Manpower Career Center. The project was carried out under the following two operational assumptions:

1. The cooperation of institutions and agencies having an interest in the delivery of health services and the development of health manpower is essential to the formulation and implementation of a workable manpower plan.

2. Involvement of consumer with institutions and agencies is necessary to accurately determine the goals, objectives, and priorities of a manpower plan.

Further, project staff recognized that the validity of any planning methodology developed must, of necessity, be based on an accurate appraisal of the current status of the training and utilization of health manpower in the planning area. The planning method must also allow for the rapidly changing and developing health care industry and trends in the development of the health manpower pool.

In light of these considerations and assumptions, the work program was divided into two overlapping phases. The determination was made to devote a majority of the first half of the project to the identification of agencies and institutions, the development and implementation of research projects, and planning for more active projects to be implemented in the second phase. The final six months of the project were to be mainly devoted to the implementation of projects to demonstrate the feasibility of the planning approach. These two phases were not considered as distinct and separate. Rather, were possible some program implementation took place in the first six month data gathering and supplemental surveys were conducted during the second six month implementation phase.

Basically the work program of the project was carried out as follows:

July-December 1972:

1. Identification of agencies, institutions, consumer group and concerned individuals for inclusion in the planning process.

2. Development of survey instruments for use in data gathering.

3. Administration of surveys and analysis of resulting information.

4. Participation in organizations and on ad-hoc committees involved in and concerned with the development of health manpower.

5. Review of literature and legislation regarding development of health manpower.

6. Development and implementation of some initial projects in connection with planning concept and identified needs.

January 1973:

1. Continuation of data gathering process.

2. Evaluation and refinement of research techniques.

3. Identification of areas where program implementation was feasible during final phase of the project.

4. Determination of areas needing further research and projects for implementation.

February-June 1973:

1. Development of survey instruments for further research.

2. Administration of surveys and analysis of newly gathered information in light of previous findings.

3. Recruitment of agencies and institutions for participation in projects.

4. Development of work programs for projects.

5. Implementation and analysis of projects.

6. Continued participation in organizations and ad-hoc committees.

7. Identification of areas where further planning activity was feasible beyond the duration of this project.

8. Finalizing of project, i.e., report writing and development of recommendations for further planning activity and regarding the planning process.

Research Procedures:

In light of the time limitations on the duration of the project, the staff recognized a necessity for narrowing the scope of the project to consider specific aspects of the broad manpower field. Thus, it was determined that the planning effort center itself around the allied health fields. This determination was based on the recognition of dynamic changes taking place in the allied health specialities and the realization that planning for physicians and nurses was carried out by their respective professional organizations. In terms of effectiveness, a duplication of the function of the AMA and NLN and that of the various ad-hoc agencies concerned with developing physician manpower was seen as unnecessary.

In considering the allied health workers, three categories were identified: 1) professional - those occupations requiring a baccalaureate degree, organized into professional organizations and requiring licensure or certification; 2) paraprofessional - those positions requiring less than a baccalaureate but some specialized training; and 3) entry-level - those positions requiring no specialized formal training or skills and generally considered back up or supportive services, e.g., housekeeping.

This determination made, the development of survey instruments was undertaken to focus data gathering activity on these occupations. Surveys were developed to determine specific information relative to the identified occupational categories in the following areas:

1. Utilization and attrition: this survey requested information regarding positions filled, vacant, budgeted, opened or closed; a matching position with those listed and information regarding personnel in those positions, e.g., number employed in each category, breakdown by sex, average age, average education, requirements for employment at that level, salary, and average length of employment; also requested was a ranking of most frequent reasons for employee turnover.

2. Hospital training programs: this survey requested information regarding programs offered or planned, funding sources and resources needed for implementation.

3. College level educational programs: this survey requested information regarding duration of program, accreditation, type of recognition on completion, type of credit earned, duration and type of clinical experience offered, admission requirements, equivalency testing, student enrollment, and faculty complement.

4. Counseling and recruitment: this survey covered types of counseling offered, methods of recruitment used, and special projects or arrangements for either counseling or recruitment.

The content of the questionnaires was determined as a result of a process of reviewing the manpower field overall. Review of literature concerning the problems of manpower development, conversations with personnel directors in hospitals and instructors of health education programs, and review of other surveys, all pointed to the inclusion of such information in any consideration of planning for health manpower. The surveys were developed around these initial concerns for assessing the current situation regarding the training and utilization of health manpower.

The surveys were implemented in two ways. Contact was made with hospitals and academic institutions serving the planning area by letters sent to administrators and personnel directors in the health care facilities. These letters which introduced the project were followed by phone contact where an interview was set up. Some surveys were then administered during the interview.

The hospital training survey was given in interview form to the personnel or training directors in the health care facilities. At each interview the director was given the survey regarding attrition and utilization to return by mail.

In academic institutions where allied health programs existed in one department, the department head was interviewed for an overall perspective and copies of the college education program survey were left to be completed and returned for each occupational program in existence. In institutions in which programs were conducted in separate departments, each program administrator was interviewed.

Analysis of the data gathered through this method raised some questions and indicated some missing though valuable information. Thus the technique was refined and two new surveys were developed and administered. The new survey for health care facilities was a revised interview to clarify and expand upon previously gathered information. The resulting information was assembled into an inventory.

The new interview for administrators of academic programs was an in-depth discussion of administrative perspective and problems. The resulting information provided indications for program planning. This interview considered program development and implementation, financing, student attrition, equivalency testing, accrediting, and cooperative arrangements with other institutions.

The overall result of research phase was the identification of barriers to effective planning, areas of concern common to academic institutions and health care facilities. From these determinations the staff was able to identify areas for action in the second phase of the project. These areas centered on furthering cooperation among institutions and educating the community to the opportunities in the health field for careers.

Active Planning:

With the identification of the two areas of involvement for active planning projects, a work program for the second phase was prepared. Major efforts in this program centered on two conferences to be held in May. The first conference was to address the need for education of the potential manpower pool towards opportunities for health careers.

The staff recognized a barrier to recruitment of students into academic programs in health in the lack of knowledge of the variety of possible health careers. The determination was made to assist in community education projects regarding health careers sponsored by local community organizations, and to plan a conference to bring together students, community residents, high school counselors, agencies, professional organizations, and representatives of academic programs to discuss the need for trained health personnel and to dispel the notion that "health professional" means physician or nurse.

The format of this conference involved a combination of the health fair and keynote-workshop techniques. Various professional organizations, academic programs and career development agencies were invited to set up display tables to facilitate distribution of literature and informal discussion with the conference registrants. A table was also set up to provide information on financial assistance. A keynote address was delivered to all participants and a movie describing the various careers was planned as were more formally structured discussion sessions. In this manner students and residents could be exposed to discussion of the problems in the delivery of health care and their relationships to the need for trained manpower as well as the variety of possibilities for careers.

The second conference was planned to reach the decision makers and program implementers in health care and academic institutions to discuss common problems and methods of solving them. Participants at this conference were invited from administrators and directors of personnel and training in health care facilities, deans and department heads and program administrators in academic institutions and professional organizations and agencies. The format of the conference was the workshop discussion in keeping with the purpose of problem solving. A keynote address was planned to provide an overall frame of reference for the workshop discussions. Each of the five workshops concentrated on one of the problems identified as common to the participants. Thus the participants were exposed to the point of view of other institutions and agencies and encouraged to cooperate in problem solving efforts.

The development of both conferences followed basically the same procedure. Staff identified and agreed upon the conference technique for addressing the two areas identified as possibilities for active planning projects. Conferences were considered an effective method for focusing attention on the two areas of concern and feasibility for completion given the time frame of the project. The staff then developed a concept outline and possible format for the conferences.

At this point resource or steering committees were formed as advisory bodies for the conference plans. The steering committee for the education opportunities conference was composed mainly of representatives from agencies concerned with the development of health manpower. The resource committee for the conference on training was composed of representatives from each size category health care facility and academic institution located in the planning area and from representatives of agencies as well. The concept and format of the conferences, as developed by staff, were presented to the committees for comments and suggestions. Revisions in conference plans were made based on these suggestions.

Both conferences were co-sponsored by a junior college in the planning area. This college hosted the conferences as well as provided the support services of its print shop and cafeteria.

Target populations for conference participants were identified in terms of the goals of the two conferences. Publicity for the conference on career opportunities was accomplished through the school system, the Model Cities youth programs, the settlement houses, and public service announcements on radio and television. For the conference on training, invitations were sent to agencies, institutions and specific individuals. Speakers were recruited from professionals working in the field of health manpower training and/or utilization and were chosen based on their expertise regarding the specific problems to be addressed. Both speakers and other participants were identified by staff in collaboration with the advisory committees.

The conferences were successfully based on the involvement of the participants in the process of planning for them. This involvement in and of itself fostered inter-institutional cooperation and demonstrated its effectiveness in this planning effort. However, the conferences themselves demonstrated the same cooperation in their implementation and seemed to foster the concept in the minds of the participants. Thus, the major result of the conferences was the decision to build upon them as a beginning point in an ongoing planning process which would continue to involve the various agencies and institutions in collaborative efforts.

Program Implementation:

Two other projects were designed to address specific problems of the actual provision of a training and upgrading mechanism and the provision of information relative to manpower planning. Both of these projects involved several institutions and agencies in a cooperative effort.

The first involved five area health care facilities of all sizes and types, from small to large, from general to specialty to neighborhood health clinic. The objective was to provide for a training and upgrading mechanism to be shared by the institutions. The goals of the project were the development of currently employed manpower through in-service training, thus avoiding the difficulities of admission to academic programs; the development of the career concept through upgrading, thus opening up the opportunity for self improvement; and the reduction of attrition through improved efficiency and increased career mobility. Cooperation in the effort would reduce cost through shared facilities, instructors and expertise, and increase the possibility of each institution implementing such a process.

The participants were chosen as those institutions willing to take part in such an activity and called to a meeting to discuss the prospects for such a project. Participants at the meeting and in the planning were directors of training and/or personnel. Consideration was given to the barriers to the success of such a project but an agreement was reached to attempt it.

It was left to the personnel directors to negotiate policy regarding release time and upgrading with their respective administrators. They were also charged with identifying potential trainees from among their employees. CHP-WSHPO manpower staff was charged with identifying possible sources of funds, and sources for instructors and resource materials. The group agreed collectively on the area in which to conduct training and the actual format and time frame for the training program.

The second project involved cooperation between a junior college, a community organization, a career development agency and WSHPO to develop a clearinghouse for manpower planning information and operations. Here again the method was one of forming a committee from agencies and institutions willing to participate to develop the project plans and a proposal for funding. In this case the goal was the gathering of information necessary for planning in manpower to be made available to concerned agencies and institutions.

Both of these efforts have been delayed. The training consortium was delayed due to decisions on the part of participating institutions on the priority of internal needs and circumstance, and the clearinghouse because of a lack of available funds. However, both projects encouraged the staff to continue in such development efforts since their delay was due to extenuating circumstances and not to a real unwillingness on the part of the participants to continue in those efforts.

Findings and Conclusions

The CHP-WSHPO Manpower Project was carried out overall from a basic operational procedure which developed into a cyclic planning process. From a beginning of reviewing current literature relative to manpower planning, utilization and training, the staff immediately began to interact with the institutions and agencies that would be affected by and involved in the planning process. Whether the specific task at hand was gathering of data, setting of priorities, or implementation of active projects, the involvement of the affected and concerned agencies and institutions was seen as necessary and found to be invaluable.

Thus the process included; the formulation of ideas by staff, presentation of those ideas for input and modification to affected agencies and institutions, development of the process for implementation of ideas with the involved agencies and institutions, implementation of the projects, analysis of results with input from the participants, and the formulation of further ideas by staff for continued planning. Involvement of agencies, institutions, and individuals in the planning process was one of the operational assumptions of the staff. This assumption was based on the theoretical concept that an agency, such as either CHP or WSHPO, without the authority to command compliance with plans developed, could best insure the implementation of those plans by involving those who would be affected. This assumption was borne out in fact.

The data gathering phase of the project best illustrates this assumption. Initial surveys were developed by staff based on a review of the literature and some conversation with those involved in the training and utliization of health manpower. The project was introduced to administrators of institutions participating in the survey by letter. Respondants to the surveys were contacted by letter and a phone call. The survey was not pre-tested. As a result, personal interviews were quite effective and useful. However, surveys left to be returned by mail were less successful.

The attrition and utilization survey was returned by only half of the participating institutions. All of the hospitals reported difficulties in completing the questionnaire citing lack of easily available data to satisfy the requested information. Had the participants been consulted regarding their methods of profiling personnel, this possibly could have been avoided. However, the biggest barrier to successful return of the survey was resistance of health care facilities to supply the required information. The participants were unclear as to the purpose of the survey and the planned uses for the information and, therefore, were unwilling to devote staff time to gather the data from personnel files. A better orientation of administrators might have relieved such resistance.

The same holds true for surveys left with academic deans and department heads for surveys to be returned by mail. Although in the case of the academic institutions almost all the surveys were returned, they were not returned promptly and, in some cases, not detailed for every program reported as offered and operational. This again can be attributed to misunderstanding of the project.

Further evidence of the need for more involvement of participation institutions early in the project can be seen in the results of later data gathering. After analyzing the first surveys, the technique was refined as were the survey instruments. Further interviewing was conducted to delve deeper into the analysis of the current manpower situation and gain information not collected in the earlier effort. By this time, the participating institutions were familiar with the project and its objectives and had participated in other aspects of the planning effort. Responses to the second data gathering effort were much more freely given and one earlier survey which had not been previously returned was forwarded to the staff.

In addition to the initial misunderstanding of the CHP-WSHPO project specifically, the data gathering phase also revealed an unfamiliarity with the process of planning for manpower, especially in the small or medium sized health care facilities. Demonstration of the usefulness of the type of data collected brought out in later phases of the project was the most effective method of dealing with questions regarding the use of the information.

Most important to the planning effort, was the realization of the lack of understanding between health care facilities and academic institutions revealed in the interviewing. Neither the academic nor the health care institutions seemed to have an accurate picture of the constraints placed on the other type of institution. This lack of understanding of the perspective of the other institution was the cause of unrealistic expectations and thus a lack of cooperation between the two types of institutions.

The data gathered regarding training in health care facilities or colleges and universities pointed up common problems of keeping up with rapidly changing technology and developing roles of health professionals, financing programs, and administrative concerns like accrediting or institutional approval of programs and staffing. However, neither type of institution seemed fully aware of the possibilities for cooperation which could alleviate some of the constraints on both.

Recognition of this situation prompted the staff to suggest a conference which would involve both academic and health care institutions as well as agencies concerned with both types of institutions to consider their common problems. The response to evaluation forms filled out by participants indicated satisfaction with the conference and a desire on the part of the participants to continue such efforts.

The entire planning project, both data gathering and program implementation, revealed some noteworthy patterns of resistance to the cooperative planning approach. Health care facilities evidenced more resistance to the approach than did academic institutions. The staff could identify perhaps four reasons for this: 1) Academic institutions must rely on health care facilities for clinical placements and are, therefore, placed in the position of having to affiliate and cooperate. On the other hand, health care facilities receive their employees after they have left the academic setting and are not obligated to accept students for clinical placement. 2) Further, admission requirements and scheduling in universities and colleges preclude extensive affiliation for training of employed hospital personnel and health care facilities generally conducted their own training as an in-house function. 3) The major purpose for health care facilities is the delivery of health services. This does not require affiliation with other institutions necessarily. 4) The general economic climate has turned the attention of both types of institutions inward as they attempt to manipulate their budgets in order to carry out programs and are, therefore, reluctant to devote scarce funds to cooperative arrangements.

Each of the above reasons is part of a major barrier to cooperative planning the staff has identified as "institutional autonomy". Both health care and academic institutions reserve their right to decide the destiny of their separate institution in isolation from one another. This isolation not only precludes cooperation between health care facilities and academic institutions, but also cooperation among health care facilities or among academic institutions. The strength of the concept of autonomy is best demonstrated by responses to questions regarding cooperative arrangements included in a survey of administrators of academic programs. The educators evidenced great resistance to the idea of cooperation even though they admitted its merits and could see no major difficulties in implementing such arrangements due to policy considerations. The resistance was based in every case on a fear of diluting the programs in existence and a fear that one institution would have to give up something without return.

This concept of autonomy carries over from the institutional to the professional level in the form of "professionalism" or "professional elitism" and manifests itself in the form of resistance to building of careers through the laddering concept. The idea of laddering was first encountered in reviewing literature and other manpower planning efforts in the city. However, the manpower staff adopted the idea of career building or "laddering" as a method of reducing attrition. The reasons for employee turnover, stated in response to the attrition and utilization survey, ranked "leave to take another position" most frequently and

"leave to continue education" second. These reasons were identified by staff as individual methods of upgrading oneself or one's position. Of eight reasons listed only two indicated employer dissatisfaction, these two ranked fifth and eighth. Other reasons all indicated employee dissatisfaction. The staff concluded that educational opportunities and career mobility within the health care facility could possibly have an effect in reducing attrition.

Career mobility is necessarily based on further training and the acquisition of the proper credentials for the new position. Further training, of course, requires more formal education in many instances. While hospitals are willing to conduct training for skills upgrading themselves, they are rarely willing to undertake extensive classroom activities and understandably so. In many cases they are also unwilling to release the employee from his obligation to the facility to continue his education. However, the staff found that most health care facilities did have some release time provisions for further training and education or were willing to implement such a policy.

Academic institutions however, were very traditionally oriented and fairly inflexible regarding admissions, scheduling, and equivalency testing. In the planning area, only the junior colleges offer night time instruction in the health occupations. There are very few nationally standarized equivalency tests in the health fields and two institutions did not utilize equivalency tests at all.

Standards set by professional accrediting organizations for academic programs make it extremely difficult for the college or university to allow credit for experience gained on the job even if the school were in agreement with the concept. Their perspective on equivalency testing is not credit for knowledge gained on the job but credit for courses taken elsewhere for no academic credit. This attitude reflects the concept that learning takes place only in the classroom, a concept which the changing patterns in the utilization of health manpower refutes. However, it is an attitude which underlies the professional registration only of those who have completed a curriculum in an approved academic program and which effectively hinders the career building concept.

The attempted consortium for training in health care facilities also experienced difficulty over the concept of upgrading of personnel. Administrators were reluctant to guarantee recipients of training through the project upgraded positions. It was the conclusion of the staff and the committee that the reasons for this reluctance were economic and that the problem could be overcome with the presentation of evidence of a worker competent at the new position after training and, therefore, deserving of upgrading. However, the problem still remained of assuring the trainee of a vacant position for him to assume when the training was completed. The decision was made here to train only in areas where there was a demonstrable need.

The process of carrying out the project revealed several barriers and obstacles to the cooperative efforts encouraged by the staff and to the cooperative planning process. However, the involvement of all types of concerned institutions and agencies in the process enabled the planners to correctly identify and understand those problems. Further, such involvement of all affected agencies and institutions assured the development of equitable solutions to the problem identified. Thus the cooperative process for planning is effective over the duration of the project in identifying and addressing the problems of the training and utilization of manpower.

Recommendations

In the further utilization of the cooperative planning process in the west side planning area or in other areas, the joint CHP-WSHPO Manpower Project staff would make the following recommendations:

1. One deterrent to the effectiveness of data gathering is a lack of understanding of the effort by the administrators of the health care facilities located in the planning area. Interviews and workshops introducing administrators to the planning concept and project goals could alleviate this problem.

2. Resistance to the data gathering effort could be alleviated by demonstration of the benefits to the hospital for collecting such information for its own use.

3. Participation in demonstration projects or cooperative efforts, especially in sensitive areas like upgrading or consortium, will be more readily undertaken if a demonstration can be made of cost benefits which would result.

4. The semi-structured interview is most effective in gathering information relative to policies, procedures and perspectives.

5. Planning projects or cooperative efforts must address a specific need within the participating institutions.

6. Meetings involving all types of affected institutions and agencies are most effective for gaining insights into, and a clearer perspective of, the total situation in which the plan must be carried out.

7. The cooperation of institutions and agencies having an interest in the delivery of health services and the development of health manpower is essential to the formulation and implementation of a workable manpower plan.

8. Involvement of the consumer with institutions and agencies is necessary to accurately determine the goals, objectives, and priorities of a manpower plan.

9. The validity and effectiveness of the manpower plan will be based on an accurate appraisal of the current status of the training and utilization of health manpower and the factor contributing to and impinging upon that situation.

10. The effectiveness of the cooperative planning process relies on a constant re-evaluation of the situation in light of the learning process attendant to the planning.

Summary

The manpower planning project has given the WSHPO greater opportunity to move towards the development of an operational health manpower planning system for the west side of Chicago. The problems and issues centered around health manpower have become very much a part of the Organization's activity, and since the Organization feels that planning must be a cooperative venture, it has moved to effectuate planning relationships with all of the visible health, education, training, and manpower development institutions and programs in the area. This effort has put the planning staff in direct contact with medical administrators, educators, program developers, funding sources and health manpower program developers. Out of this interaction has come a spirit of cooperation, communication, commitment and joint planning efforts that will greatly enhance and facilitate further development and refinement of the process. As a direct result of the project, WSHPO has been directly involved with other agencies and organizations in the area for the purpose of developing specific programs designed to help meet immediate needs and provide structures for on-going planning and developmental activities. Foremost among these are:

1. Project VEHTS task group - a program development effort to see that medically trained corpsmen get a chance to turn the knowledge and skills they have gained in the service into negotiable credit in the civilian educational and employment systems. This group is composed of representatives from the Malcolm X Community College's Allied Health Department, Central YMCA Community College's Human Services Division, Health Careers Council of Illinois, Robert Nathan Associates, Inc., and the WSHPO.

2. An advisory group to develop progressive liaison between high school health occupations programs, community college Allied Health Programs and institutions of higher learning with programs in the health sciences. This group is composed of representatives from the Chicago Board of Education's Health Occupations Program, Malcolm X Community College, the University of Illinois Medical Opportunities Program, and the WSHPO.

3. A consortium of agencies, organizations and institutions to develop a health manpower planning, information and operations, clearinghouse for the west side. A program proposal has been developed and submitted for funding. Participating in this venture are the Christian Action Ministry, Malcolm X Community College, the Human Services Manpower Career Center and the WSHPO.

4. In its role as a promoter and stimulator, WSHPO has spearheaded a joint manpower planning effort to develop training programs to upgrade area residents who live in the Model Cities Target Area and work in west side health facilities and/or programs. Involved in this process has been the Mayor's Office of Manpower, the Health and Hospitals Governing Commission of Cook County, the National Alliance of Businessmen's JOBS Project, the Martin Luther King Jr. Neighborhood Health Center, the Mile Square Neighborhood Health Center, Bethany-Garfield Park Hospitals, Mary Thompson Hospital and Franklin Boulevard Hospital. In addition WSHPO has developed and maintained working relationships that have interest in health manpower planning and development. Some of these are the Inter-Agency Task Force for Health Manpower, the Chicago Health Manpower Consortium Inc., the Chicago Area Society for Health Education and Training, State of Illinois Health Care Licensure Commission, Chicago State University-West Center, the University of Chicago's Hospitals and Clinics Department of Education and Training, Loyola University's School of New Learning and Northwestern University's Design and Development Center.

The CHP-WSHPO manpower project has demonstrated that the various entities involved in the development of health manpower recognize the need for a coordinating agency or centralized body to bring the individual components of a loose system together for the maximum, efficient and effective utilization of their resources as a means of improving the health care delivery system by providing it with the proper proportions of trained manpower needed to operate a comprehensive health care delivery system.

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SURVEY INSTRUMENTS

Date_____

_____
Name of Facility

_____
Address

_____
City State Zip Code

If your institution falls into one of the following catagories please check the appropriate box.
(Check one or more)

- General Hospital ☐
- Rehabilitation Institute ☐
- Nursing Home ☐
- Resident Care Facility ☐
- Mental Health Facility ☐
- Extended Care Facility ☐
- Health Clinic ☐

Other, Specify _____

-Methods of Recruitment - (Check one or more)

- Radio ☐
- T.V. ☐
- Newspaper ☐
- High School Counselor ☐
- Magazines ☐
- Mailing Lists ☐
- Vocational Schools ☐
- Employment Service ☐
- Training Center ☐
- Personal Referrals ☐
- Health Career Days ☐
- Other, Specify _____

ATTRITION INDICIES

Fiscal Year	1971	1972
Total Personnel Hired		
Professional		
Technical		
Intermediate		
Entry Level		
How many applications were submitted to your employment office for Para-Professional Positions?		
How many positions were opened in various departments due to retirement, death, dismissal, illness, etc.?		
How many entirely new Para-Professional positions were created?		
How many Para-Professional positions were closed due to automation, budget, cuts, etc.?		
How many Para-Professional Positions were allowed for by budget but were not filled ?		

ATTRITION INDICIES

Fiscal Year	1971	1972
How many Para-Professional positions were allowed for by other standards but were not filled? (such as: organizational charts, etc.) Specify Standard_____		

In your opinion, what is the chief cause or causes of employee turnover in Para-Professional positions. (Please list in order of magnitude.)

1._____

2._____

3._____

Projected Manpower for Fiscal Year '73

	Fical Year '73
What is the number of new professional positions to be opened?	
What is the number of professional positions to be closed?	
What is the number of para-professional positions to be opened?	
What is the number of para-professional positions to be closed?	

Describe the duration of your fiscal year.

Beginning (month) _____

Ending (month) _____

CHARACTERISTICS AND ATTRITION INDICIES OF ENTRY OR LOW-LEVEL EMPLOYEES IN THE HEALTH CARE INDUSTRY

Title	Number	Ave Age	Male	Female	Ave. Education	Length of Employment	Education and skills requirements	Average Salary Annual	Number Hired 71-72	Current Vacancies
ttendant										
linical ase Work Aide										
linic Clerk										
linical ocial wk. aide										
ommunity Health ide										
onsumer dvocate										
ental Asst. on-Certified										
ietary Aide										
lectro ardiograph echnician Aide										
nvironmental ide										
mily Health rker										
od Service nager										

CHARACTERISTICS AND ATTRITION INDICIES OF ENTRY OR LOW-LEVEL EMPLOYEES IN THE HEALTH CARE INDUSTRY

itle	Number	Ave. Age	Male	Female	Ave. Education	Length of Employment	Education and skills requirements	Average Salary Annual	Number Hired 71-72	Current Vacancies
ealth dvocate										
ealth Education ide										
ome Health ide										
nhalation herapy Aide										
edical Record ide										
ursing ide										
ccupational herapy Aide										
ffice ssistant										
rderly										
harmacy ide										
hysical Therapy ide										
hysician's ssistant										

CHARACTERISTICS AND ATTRITION INDICIES OF ENTRY OR LOW-LEVEL EMPLOYEES IN THE HEALTH CARE INDUSTRY

itle	Number	Ave. Age	Male	Female	Ave. Education	Length of Employment	Education And skills requirements	Average Salary Annual	Number Hired 71-72	Current Vacancies
rosthetic ide										
syciatric ide										
ecreation herapy Aide										
-Ray Laboratory) ide										
isual are Aide										
ard Clerk										

This questionnaire was filled out by _____

Position _____

DATE _____ NO. 0002-17

BEST COPY AVAILABLE

INTERVIEW SCHEDULE FOR ALLIED HEALTH TRAINING ADMINISTRATORS

These are questions to be asked of the administrators of the health education and training programs.

Name of institution _____

Address _____

City _____ State _____ Zip _____

1. Interviewers name and title _____

2.

PROGRAM NAME	ADMINISTRATORS NAME
a. _____	a. _____
b. _____	b. _____
c. _____	c. _____
d. _____	d. _____
e. _____	e. _____
f. _____	f. _____
g. _____	g. _____
h. _____	h. _____
i. _____	i. _____
j. _____	j. _____
k. _____	k. _____
l. _____	l. _____

3. Does your institution have any new allied health or health occupations training programs projected for the next 1 to 5 years? If so, please describe and indicate stage of development.

4. What are the projected faculty needs for new or expanded allied health programs over the next (5) five years? (What level of education and area)

5. What are the primary funding sources for your allied health programs? (temporary or long term)

6. Do you foresee any major problems or trends which may impede expansion of current programs or hamper the planning development and implementation of additional ones.

7. What do you feel that the West Side Health Planning Organization can do to enhance the availability and optimal distribution of allied health manpower for the westside of Chicago?

8. Please give any additional information which you feel to be pertinent to this study or beneficial to the recruitment, training and retention of manpower for the medical and/or allied health professions.

DATE _____ (74-79)

NO. 0003-123

DESCRIPTION OF COLLEGE HEALTH EDUCATION PROGRAMS

ignore)

This questionnaire is designed to obtain information relative to the availibility of allied health occupations training programs on the westside of Chicago. Most of the questions can be answered by drawing a circle around a number in the right hand margin of the questionnaire. However, blank spaces are provided for answers which have not been included.

(please ignore)

A. Name of College, University, or Medical School: _____ (11-73)

_____

B. Address: _____ (11-32)

City: _____ (33-48) State: _____ (49-50) Zip: _____ (51-55)

C. PROGRAM DESCRIPTION

1. Program name: _____ (15-52)

2. Who is the primary administrator for this program? _____ (53-73)
(Name and Title)

D. 3. In what year was this program established? _____ (15-16)

4. Is the length of this program

9 months ? _____ 1
18 months ? _____ 2
36 months ? _____ 3
Other/specify ? _____ 4

5. What agency(s) accredits this program? _____

_____ (18-19)

6. Is academic credit given for this program?

Yes _____ 1 (20)

NO _____ 2

7. Is the basic unit of credit

Quarter hours? _____ 1
Semester hours? _____ 2
Other/specify? _____ 3 (21)

(please ignore)

8. What degree is conferred upon completion of this program (22)

AA _____ 1
BS _____ 2
Certificate _____ 3
Diploma _____ 4
Vocational education certificate _____ 5
Other/specify _____ 6

9. Is clinical training a part of this program? (23)

Yes _____ 1
No _____ 2

10. Where is clinical training offered (24)

On campus? _____ 1
Other/specify _____ 2

11. How long is clinical training (25)

3 months? _____ 1
4 months? _____ 2
6 months? _____ 3
12 months? _____ 4
Other/specify _____ 5

12. What are the entry requirements for this program (26)

High school diploma or equivalent? _____ 1
2 years of college or an AA degree? _____ 2
3 years of undergraduate work? _____ 3
Bachelors degree? _____ 4
Masters degree? _____ 5
Other/specify? _____ 6
One of the above and additional courses in the following area(s) specify _____
_____ 7

13. Are equivalency or proficiency tests honored in lieu of formal training? (27)

Yes _____ 1
No _____ 2

14. In what months do you admit new students? (28)

Specify _____

15. What is the full time student enrollment? (29-31)

Specify _____

16. What is the part time student enrollment?

Specify _____ (32-35)

17. What is the capacity enrollment?

Specify _____ (36-38)

18. What is the projected enrollment for next year?

Specify _____ (39-41)

19. Do you offer night classes in this program?

Yes _____ 1 (42)
No _____ 2

20. Is this entire program available at night?

Yes _____ 1 ((43)
No _____ 2

21. How many full time faculty members are in this program?

Specify _____ (44-45)

Part time

Specify _____ (46-47)

22. Have the students of this program experienced any difficulty in transferring credits to other schools, please elaborate?

_____

_____

_____

_____

23. Who is the respondent to this questionnaire?

Name and Title _____

_____

If you have any additional comments or questions, please feel free to use the space below and the back of this questionnaire if necessary.

(please ignore)

NO. 0004-_____

This questionnaire is meant to be presented in person during an interview with a health related counseling or recruiting service (i.e., a medical schools's counseling services, project 75, etc.). The purpose of this survey is to determine the involvement of schools and counseling service in recruitment for health related programs. 00034

1. Do your services recruit or counsel for health related EDUCATION programs?

   YES

   NO

2. Do your services recruit or counsel for health related EMPLOYMENT programs?

   YES

   NO

Are you recruiting for or referring individuals to any health related programs, if so please list these programs by project title or if no project title exists, list by the name of the institutions sponsoring that program.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

(use back side of this sheet to make additional entries).

Recruitment and/or counseling for the above programs are handled:

Centrally (by one person)

By Department or Program

Explain_____

_____

Recruiting Services

Please check the appropriate space if your recruiting services involve any of the following media methods:

(check one or more)

Radio

Television

Newspapers

Magazines

Mailing Lists

High School Counselors

College or University Counselors

Vocational Schools

Employment Services

Training Centers

Personnel Referrals

Health Career Days

Other, Specify _____

_____

If your services involve recruitment from any of the catagories of people listed below please check the appropriate box. (check one or more)

Students

Ex-Servicemen

Ex-Prisoners

Handicapped

Hospital or clinical workers

Community in which you are located

Community in which the sponsoring institution is located

Other, Specify _____

How? _____

Counseling Services

Does your organization employ counselors?

Full Time

Part Time

None

Does your organization make use of counseling services located outside your facilities?

Yes

No

If yes explain: _____

_____

Please, briefly explain the services conducted at your facility. (i.e., if your counseling or recruiting service involve financial assistance, educational programs career opportunities, etc.).

Do you in your opinion feel that your organization's operation may be facilitated by affiliation with Comprehensive Health Planning, Inc., (our functions being planning, coordination and information distribution concerning health related industries)?

DATE_____ NO. 0005

INTERVIEW SCHEDULE FOR ALLIED HEALTH TRAINING ADMINISTRATORS

This interview schedule is used in interviewing training managers in health care facilities. Its purpose is to help define manpower problems in the para-professional and non-medical positions. It is designed to help identify all other problems which are relevant to the optimal usage of indigenous personnel.

Name of institution_____

Address_____

City_____ State_____ Zip_____

1. Interviewees name and title_____

_____

2. Type of health care facility_____ bed capacity:_____

   a. Short term gerneral hospital
   b. Long term general hospital
   c. Psychiatric hospital
   d. Tuberculosis hospital
   e. Other specialty hospital
   f. Specify specialty_____
   g. Extended care facility
   h. Nursing care facility
   i. Resident care facility
   j. Neighborhood health center
   k. Health maintenance organization

3. How is employee performance evaluated and by whom?

4. How do you determine a need for a training program?

5. In your facility in what areas are there manpower needs, what areas do you predict a probable manpower shortage?

6. Please define the community you serve (geographically)

7. Please describe the social and economic level of the community in which you are located.

8. How would you consider your relationship to the immediate local community?

9. Has the recent economic conditions presented any outstanding problems in terms of labor, building equipment, type of medical services you are being asked to render, sources of payment, availability of govern ental nad other grants, etc?

10. Of what social, economic and educational backgrounds are the people most frequently employed in the entry-level and non-medical positions?

11. Has the upper administration expressed any sentiment toward inservice training and upgrading? If so, how would you interpret their sentiment?

12. Listed below are some definitions of types of training programs. Please check the types of training offered in your institutions?

___a.	orientation	an activity of short duration for new employees designed to familiarize them with the institution, its policies, procedures, and goals; conducted by staff
___b.	in-service	short term, periodic activity designed to keep the employee up to date with new techniques and concerns; conducted by staff
___c.	on-the-job	task specific, skills, upgrading of variable duration; may be performed at the work station or in a separate classroom setting, conducted by hospital staff or an outside agency; generally of prolonged duration

____d.	job-related education	classroom activity in the theory behind the practice; designed to improve employee understanding and broaden horizons; may be conducted by hospital staff or an outside agency; generally of prolonged duration
___e.	basic education	assistance in basic skills, o.e., English, reading and math, leading to GED certificate, designed to prepare employees for futher training or employment opportunities, of variable duration
___f.	formal training	definitely long-term, classroom activity with associated practical experience in the new capacity leading towards professional certification.

13. Do you have a separate training department, or a person who is primarily responsible for training?

13a. Do you have any training programs which are conducted in cooperation with other hospitals? Please explain the arrangements.

14.

PROGRAM NAME	ADMINISTRATORS NAME
a._____	a._____
b._____	b._____
c._____	c._____
d._____	d._____
f._____	f._____
g._____	g._____
h._____	h._____
i._____	i._____
j._____	j._____
k._____	k._____
l._____	l._____

15. Do you have any programs for Spanish speaking employees?

16. What is the cost of operating your training programs?

17. Does your institution have any new allied health or in-service training programs projected for the next 1 to 5 years? If so, please describe and indicate stage of development.

18. What are the primary funding sources for your in-service training programs? (temporary or long term)

19. Please give any additional information which you feel to be pertinent to this study or beneficial to the recruitment, training and retention of manpower for the medical and/or allied health professions.

NO. 0006

FOLLOW-UP INTERVIEW OF ALLIED HEALTH EDUCATION PROGRAMS

1. What are the key factors considered in the decision to implement a particular curriculum? e.g., What made you choose MLT program over another?

   a. student interest
   b. suitability of material for college level instruction
   c. cost of operating - source of funding
   d. availability of instructors
   e. laboratory access required
   f. clinical practicum
   g. cooperation with other departments
   h. classroom space
   i. administrative support

2. In developing new curricula, is departmental approval sufficient or must the school administration also approve? (Yes-No) How much time does the approval process take?

   a. less than 1 month
   b. 1-3 months
   c. 6 months
   d. 1 academic year
   e. 1 calendar year
   f. more than 1 year

3. Must new programs also be approved by authorities outside the institution, e.g., the IJCB? (Yes-No)

4. What improvements would you suggest for the approval process?

   a. remove outside approval
   b. reduce approval time
   c. reduce paperwork
   d. implement new process/specify

5. Would you say there is a problem finding instructors? To what would you attribute this problem? How have you circumvented it?

   a. lack of personnel qualified to teach
   b. lack of interest in teaching by qualified personnel
   d. other_____

6. With what kinds of hospitals do you prefer to develop clinical affiliations? On what terms do these affiliations exist?

   a. small
   b. large
   c. general
   d. speciality
   e. teaching

7. Many hospitals are experiencing financial problems of their own, how does this affect the development of clinical affiliations?

a. no effect
b. increase willingness to affiliate
c. reduces willingness to affiliate
d. require payment for service
e. other

8. How are the programs financed and what are the costs?

a. government financed
b. general school budget
c. special tuition
d. in-kind services

a. teacher salaries ___%
b. administrative expense ___%
c. physical facilities ___%
d. other ___%

9. Do you use proficiency or equivalency tests for advanced placement of students with some experience?

What kind of test is used? oral_____completion_____
multiple choice_____essay_____performance_____

If so, has this been effective? What are the problems you've encountered with such testing?

If not, have you considered the use of such tests? What influenced your decision not to use them?

10. Do you use tests standardized by a testing service or make up your own? What are the advantages of the (tests used) ? the disadvantages?

    a. concise
    b. measure student's knowledge accurately
    c. measure student's skills accurately
    d. accurately predict student's proficiency and ability to eliminate particular courses

    Are these tests given to transfer students?

11. Of students beginning the curriculum in any year, how many of those same students will probably complete the program?

    a. 90-95%_____
    b. 80-90%_____
    c. 75%_____
    d. 50%_____
    Other_____

12. For what reasons do students drop out of the program?

a. transfer to other schools
b. transfer to other departments (same school)
c. financial problems
d. family problems
e. find employment
f. disinterest
g. fail

13. How does the attrition rate affect the cost of the program?

a. no effect
b. increases minimally
c. increases substantially

14. How does the attrition rate in this program compare to that of other programs in the college? How would you account for the difference?

    a. greater
    b. equal
    c. less

15. Is accreditation of programs by professional agencies required by this institution? If not, what factors contribute to the decision to obtain accreditation? If so, how is the decision made which agency's accreditation to seek?

    a. required by funders
    b. helps attract students
    c. helps attract instructors
    d. assures quality
    e. adds status to program
    f. other

16. Is the accrediting process itself difficult or time consuming? (Yes-No) How long must a program exist before it can be accredited?

a. 1 year
b. 2 years
c. more than 2 years (specify)

17. Do you feel the accrediting is worthwhile (Yes-No) Does it accomplish its objectives?

	Yes	No	
a.	____	____	standardize curricula
b.	____	____	assure quality education
c.	____	____	guide to establishment of programs
d.	____	____	further professionalism

18. How do you think the accrediting process could be improved?

a. require less paperwork
b. more frequent site visits
c. less frequent site visits
d. more relevant questions on forms
e. increased interagency cooperation
f. establish grading system to differentiate types of curricula
g. establish completely new system (specify)

19. Does this program have any cooperative arrangements with other schools through shared facilities or instructors, in a consortium type arrangement?

School Name_____

a. shared instructors
b. shared labs
c. shared libraries
d. shared classroom facilities
e. combined classes

20. Has the idea of a consortium arrangement with other schools ever been discussed?

21. What would be some of the problems in implementing such an arrangement?

a. reconciliation of time sequence semester vs. quarter
b. reconciliation of time requirements hours in lab vs. lecture
c. reconciliation of academic credit
d. reconciliation of grading systems
e. cost accounting
f. practicum requirements
g. transportation between institutions

22. Do you think such a consortium would help alleivate the problems of shortages of allied health personnel?

If so, how would you suggest such arrangement be initiated?

a. government
b. hospitals affiliated with schools
c. schools themselves
d. professional groups

If not, what would you suggest as a method to increase the personnel supply?

PROJECT WORKING PAPERS

Accessibility of Allied Health Programs in Academic Institutions in the West Side Planning Area

The most obvious need in the health industry is for trained doctors. The physician shortage is evident in every area of the nation and places comprehensive health care out of the reach of most of the country's population. This shortage of the most important member of the health team along with the increased knowledge and complexity of health care delivery has probably had the greatest impact on the reconsideration of health delivery systems.

Many of the proposed changes in the traditional health delivery system are designed to increase efficient use of the physician's time by introducing specialists to take over routine jobs. The proposed Health Maintenance Organization shifts initial patient screening from the physician to other members of the health care team. In addition, nurse practitioner and physician's assistant programs have the same effect. The trend seems to be one of reserving the physician's time to function in diagnosis and treatment, leaving screening, testing, and some follow-up care to carefully trained specialists.

This trend not only maximizes the physician's knowledge and skills, but it also places new emphasis on allied health personnel, creating several new specialities while expanding the responsibilities of others. While the whole area of public health is expanding to include more responsibility as well as new personnel, hospitals and clinics are looking to LPN's to dispense medication and requiring more direct patient contact of nurse aides.

The new responsibilities of the allied health worker require that he increase his knowledge and refine his skills. On-the-job training will soon be inadequate as a means of training or upgrading the allied health worker. Further, certain steps must be taken to assure his competence in delivering quality care. Thus as the entire structure of the health field is changing, new programs must be devised to train personnel and certification standards set up for heretofore non-existent positions.

In the allied health field itself, these changes are already taking place. Professional organizations in several occupations have been in existence for quite some time and have established national registries and criteria for licensure which have been adopted by educational institutions as standards for their academic programs. Such organizations include the American Registry of Radiologic Technologists, the American Society of Clinical Pathologists, and the American Association of Dental Assistants. This recognition, i.e., license, registration, or certificate, allows the worker additional responsibility, greater opportunity for advancement and the attendant benefits in salary and staff privileges.

The west side of Chicago is served by several educational institutions offering a variety of programs in allied health. The Chicago Board of Education's Bureau of Health Occupations offers a work-study program in the allied health fields. Theirs is a two year curriculum involving junior and senior high school students. A business college in the area offers programs in the

medical clerical occupations. There are also programs in three (3) junior colleges, two (2) senior colleges and two (2) medical schools. A third medical school is scheduled to open in 1973 and will also offer programs in the allied health fields.

Accessibility of Programs by Location

Most of these educational institutions are located in the Loop area or at the nearby west side medical center, placing them in the extreme eastern portion of our planning area. Such location could pose a transportation problem for students living or working closer to the western city limits. Although the Loop and the medical center are easily accessible via public transportation, the dependability of such transportation varies with the weather, and it is entirely possible that home residences are not within easy reach of the Chicago Transit Authority. Hospitals located in the western portion of the target area would of necessity have to consider transportation problems in release time policy if they were to enroll employees in the available programs.

Of the 21 hospitals and clinics in the area, seven (7) are located in the west side medical center. Transportation between institutions within the medical center itself can probably best be accomplished on foot. Public transportation along the bounding streets of the area is generally good; however, through the center itself long waits for buses and slow moving traffic can make the bus trip longer than the walk.

Three (3) of the other 14 health care facilities are on a direct

route to the medical center area. Two (2) of these are located close to the rapid transit, one (1) ten minutes away by train, the other 25 minutes away.

Three (3) more hospitals are on fast, though indirect, routes to the medical center. Travel would involve a transfer between buses, but the distance to be traveled is relatively short and the service on the routes involved is frequent.

The remaining eight (8) hospitals and clinics are not within easy reach of the medical center by public transportation. Although the trip would not involve more than one (1) transfer, these hospitals are located near local routes where service is infrequent and/or the route to be taken is long and indirect.

Of course, once arriving at the medical center area there is still the problem of finding a particular school. The schools are all located on major bus routes. This may involve another transfer or a few minutes walk. To get to the Loop, 5-15 minutes should be added to the travel time. Once in the Loop, a transfer will be necessary in most cases. The trip to schools may take up to 45 minutes or an hour from the hospitals and clinics in the target area.

Transportation to and from the business college, which is in an awkward location, is mitigated by their willingness to send instructors out for on-site instruction when the classes are of sufficient size. Considering this possibility in light of the clustering of hospitals and clinics in the area, health care

facilities could band together for joint programs. This would provide classes large enough to warrant on-site instruction and cut down on commuting time.

The time factor in commuting to classes will play an important part in the decision to implement training through local educational institutions. In considering release time policies the hours spent traveling may make such participation unfeasible from the view of the hospital administration.

Accessibility by Admission Standards

Participation in courses offered at local colleges is hampered by the colleges' admissions policies. In most cases, participation in any course requires admission to the college or university. Even though separate departments for allied health programs have been set up, full admission to the institution is required. In the case of upper division universities and medical schools, admission to the department of allied health are more stringent than admission to the institution.

Business College

Easiest to enter is the business college. Participation in any course taken for no credit is permissible as long as the student is "qualified", i.e., has adequate prerequisite knowledge, for the course. To take courses for credit, the student must have his high

school diploma' or GED certificate. This does not mean the student must have them to enroll in the course. It does mean that in order to obtain a diploma from the school, the student must have the equivalent of the high school education in addition to his work at the college. For certificate courses, the student must take entrance exams if the student does not have his high school diploma or equivalency certificate.

The business college offers instruction in the medical and clerical fields and basic education. It is accredited by the Illinois State Department of Public Instruction, but the allied health programs do not have AMA or AMRA accreditation. The student population is mainly composed of people eligible for training under the MDTA program and have their tuitions paid from MDTA Program funds.

Junior Colleges

Of the three (3) junior colleges, one (1) has an open door admission policy. Any one wishing to take courses at this institution may do so, but academic credit for course work is not released until the student has received his GED certificate. This college has been approved for veterans' education by the state, it is also accredited by the North Central Association of Colleges and Secondary Schools and the Illinois State Department of Public Instruction. Programs in allied health include curricula in dentistry, dietetics, medical records, management, and the various therapies and technologies. Diagnostic tests are used to determine the educational level of the entering student.

The other two junior colleges, both part of the city college system, have more traditionally stated admission policies. Focusing on residents of Chicago, these colleges accept graduates of accredited high schools, transfer students from other colleges, or special students. The special student category includes applicants without high school diplomas or GED certificates. Much of the student population of these colleges fall into the special students class. Applicants must also have a social security number, and incoming freashmen are given the American College Testing Program tests.

Upper Division Universities

The upper division universities are approved by several accrediting organizations. Each curriculum in the allied health field is approved and accredited by the related national professional organization and the AMA. Graduates of these programs are prepared to pass examinations for licensure and registration by the professional organizations and receive the bachelor's degrees. However, the upper division programs are limited to medical laboratory technology and radiologic technology.

Admission to the upper division universities is strongly dependent on a successful high school career. A high school diploma and successful completion of the college board exams, e.g., SAT and ACT, are necessary for admission to the university. For admission to programs in allied health fields, the student must have completed coursework in the basic college core curriculum, usually two years worth of college work or have his associates' degree when he is admitted to the univer[illegible].

Medical Schools

The two medical schools in the area have admission policies similar to those of the upper division universities. One requires that entering freshmen have ranked in the upper half of their high school graduating class and have completed specific courses while in high school. Admission to allied health programs at this institution is dependent on a particular grade point average in the preprofessional curriculum.

While entrance into the medical schools themselves is generally required for allied health students, one of the colleges is planning a program especially for upgrading currently employed hospital personnel. This program would allow health workers to enter special courses or programs, taking only what is needed and not the entire college curriculum. These courses would be designed to serve as refresher work or upgrading sequences. They would be of short duration and would not require admission to the university. However, they are planned to involve hospital employees and therefore, will in all probability be conducted in conjunction with the employing institution as part of their in-service training efforts.

The medical schools at present offer a limited variety of programs in the allied health fields. Medical laboratory technology and radiologic technology, physical and occupational therapies, medical dietetics, and medical records administration are the only curricula available at present. Plans are being made to offer other curricula at a later date by one of the colleges whose allied health division is relatively new.

Accessibility by Cost

A major factor in considering participation in college programs is cost. Tuitions range from the nominal $26.00 service fee at the city colleges to $2,300 per year at one of the medical schools for full time students. This cost can be lessened by taking a reduced course load and paying tuition at rates per credit hour ranging from $24.00 per quarter hours to $40.00 per semester hour. Including lab fees (usually $10) one three hour course would then cost from $82.00 to $130.

These rates are generally too high to be assumed by the employing hospital and also tend to be out of the reach of the allied health worker himself. Thus, the worker who would not ordinarily have been able to go to college is also unable financially to receive the training which would upgrade his skills and job classification on his own.

Exceptions to this general rule can be found in the business college or the junior colleges. Students eligible for Manpower Development and Training Act funds of the Department of Labor may have their training at the business college financed through this program. Two of the junior colleges, as part of the city college system, have unusually low tuition rates for city residents. The junior colleges also have good scholarship resources available for students unable to meet the tuition requirements.

Scholarships and grants are also available at the universities and medical schools. However, these awards are made on a competitive basis similar to admission standards.

Programs

A wide variety of programs in the allied health fields are available to west side residents through the academic institutions serving the area. This variety is offered mainly by the junior colleges which take up the major burden of the formal training of allied health workers. Most of the programs offered are duplicated in at least one other institution. Only two programs are not duplicated.

Six or eight institutions offer programs in radiologic technology and medical laboratory technology. These are the only programs offered at the two universities, one of which has more than one curriculum in the medical laboratory. Hospitals do not consistently report needs for personnel in these two fields, however they do lend themselves well to full fledged college programs. Only two of the six programs are filled to capacity enrollment. One of them, offered by a junior college, has a full time enrollment at 1½ times its planned capacity, while another, offered by a university, has an enrollment of less than half its capacity.

There are five programs in dietetics offered at four institutions. Four institutions have programs in medical records administration. This seems to follow a pattern of personnel needs in hospitals and these fields also lend themselves well to classroom instruction.

The two physical therapy programs offered in the area are offered at the two medical schools, while one of the junior colleges offers a course in physical therapy assisting. Occupational therapy is offered only at one medical school. While there does not seem to be a critical need for personnel, hospitals do report shortages in these fields.

With the growing acceptance of the neighborhood health center concept, the need for community health aides is increasing. However, there is only one institution, a junior college, which offers a program in this category. This is a relatively recently created occupational category for which curriculum essentials have not yet been established. Programs in dental assisting and inhalation therapy are also offered at the junior colleges. In recent years curriculum in these fields have been standardized and accredited. Health facilities management and operating room technology are also offered in the junior colleges. These are programs for which curricula are just becoming standardized. Many of these positions have low priority in hospital accounts of personnel shortages because they can be filled by existing personnel through on-the-job training programs.

Accrediting:

All of the programs except those offered by the business college have multiple accreditation. Each of the junior colleges universities and medical schools are accredited by the North Central Association of Colleges and Secondary Schools. In addition, they all generally are accredited by various state offices also. Further each program in allied health carries the accreditation of a joint committee of the AMA and the relevant professional organization. Several of the programs hold accreditation from more than one professional group.

The approval signified by accreditation certifies that the curriculum contains the minimum information considered necessary by the accrediting organization. It does not actually standardize the various programs in that particular field. For example, programs in

medical laboratory technology at the various schools in the west side planning area vary in length from 4 academic quarters to 4 years. The clinical practicum vary in length from 4 months to an entire year. The prerequisites and curricula differ accordingly in each institution. However, all the programs are accredited by the AMA and the ASCP, and therefore meet their minimum standards. These programs are designed to prepare students for licensing examinations administered by the national professional organizations. They also allow him to join these organizations or become listed on national registries all of which enhance the professional standing of graduates of these programs.

The business college, however, is accredited only by the Illinois State Department of Public Instruction and no other accrediting agencies. These programs prepare competent workers but do not have the prestige more accreditation would convey.

Duration:

Many of the programs in allied health are offered at least in part in night time classes. This makes them more easily accessible for students who must work during the day. However, day time hours are necessary for those courses requiring clinical or laboratory experience. The junior colleges offer night classes in most programs while the universities and medical schools offer no night classes at all.

Full time students would need from two to five years to complete the program curriculum giving at least three days a week to classroon

activity. Part time students would need more time to complete their requirements. Clinical experience would involve work in laboratories or hospitals either full or part time depending on the curriculum being followed.

Unfortunately, there are few ways to cut down on the amount of time necessary to complete the programs unless the student were to double up on his course load. The universities and medical schools will accept credits transferred from other universities, junior colleges or accredited institutions of higher learning. They will also accept the associates degree in lieu of the first two years of college work at a four-year college. Little or no credit is offered for actual experience gained working in the allied health fields. One university will give advanced credit to veterans for courses taken in Service School and for CLEP and USAFI courses following the guidelines of the American Council on Education. It is the only school which reports allowing such credit. Experienced allied health workers, therefore, would have to complete the entire curriculum along with the practicum to receive a degree or diploma.

Conclusions

The admissions and financial aid policies of the surveyed universities and medical schools are geared toward the "typical" college student who has just graduated from high school, is still supported by his parents, and has no real responsibilities other than continuing his education. While a substantial percentage of their students may come from the Chicago area and the state of Illinois, these schools receive applications from across the country and base their admission decisions accordingly. They are interested in attracting

The "best qualified" students in the traditional sense of the phrase.

Residents of the west side planning area and allied health workers may not fit the traditional sense of the phrase "best qualified" any more than they may typify college students. The west side resident is a victim of the inferior high school education which plagues ghetto residents all across the nation. Thus even when they do complete high school, they may experience difficulty in national competition for college admission. Frequently, these students are expected to find a job after high school and at least support themselves if not help support their families. The universities and medical schools in the area are priced outside the ability of most west side families to pay tuition. With financial aid based on much the same criterion as admissions, west side residents are doubly barred by circumstance from attending these schools. Motivation is a key factor in anyone's decision to attend college. In many cases full time study at an expensive four year institution is recognized as an unrealistic ambition and ghetto high school students are not encouraged by their families to even attempt such study.

The junior colleges focus their attention on just these students who are left out by universities and medical schools. Drawing their student population from Chicago, the junior colleges conduct extensive recruitment campaigns making heavy use of newspaper and radio advertising. These colleges attempt to present themselves as resources for the entire community making themselves available for consultation with community organizations. One of the junior colleges on the west side even operates a day care center for the children of its students. Through this kind of community contact, the west side residents have become familiar with the junior colleges as supportive institutions.

Admission standards in the junior colleges in terms of academic performance in high school are also not so stringent as they are in the universities. Due to the junior colleges' main interest in Chicago residents, competition from across the country is virtually non-existent. Most important, a potential student may be admitted in special student status if he does not already have his high school diploma. This special student category affords high school drop outs and people over the usual college age a second chance at a complete education.

The unrelenting insistence of educational institutions on academic credit amounting to from two to five years of classwork is partially reinforced by accrediting standards. The institution must meet the requirements of the various accrediting agencies. These requirements are set up to assure the student of quality education and employers of competent personnel. However, they also inhibit the acceptance of equivalent experience outside the classroom. Thus students are often required to take courses which duplicate their own previous knowledge and prolong the formal education process.

Efforts at assuring minimum standards of education also inhibits the transfer of academic credits from one institution to another. While all the institutions state that they will accept credits from other accredited institutions, some also state as policy the maximum number of credits they will accept. All of the institutions chose which of a student's credits they will accept. As a result, students transferring between institutions generally lose credits. They may even have to repeat courses which they have already completed at

the new institutions. All of this serves to prolong rather than speed up their progress through the programs.

Students who have experience in the allied health field must complete the entire program curriculum to receive their degree, despite their prior knowledge gained through actual experience in the field. They may choose to improve their skills and knowledge by registering for only one or two courses for no academic credit towards a degree. This will improve their competence as workers, but will not afford them the added prestige and attendant wage and privilege benefits of the degree.

A further discouragement from participation in academic programs to hospital employees are hospital in-service training programs. Hospitals, because of time and cost considerations, generally conduct skills upgrading programs for allied health workers as an in house function rather than in conjunction with academic institutions. Problems involving hospital release time policy play a major factor in this consideration along with the cost per student for the academic programs. Because hospitals can more easily train their personnel themselves, currently employed allied health workers can received needed instruction on-the-job. This is, of course, more convenient for those with family responsibilities or restrictive financial situations. Hospital in-service training also tends to minimize relearning.

The junior colleges are the most easily accessible to west side planning area residents because of relaxed admission standards and lower tuition rates. The time considerations for participation in

academic programs in allied health, including class hours per week, travel time to and from the institution, and duration of the program to receive a degree, form the major deterrent to attendance of even the junior colleges by west side residents. However, unless the student receives substantial financial grants-in aid, he is unlikely to be able to attend the junior colleges.

Because of the rigidity of existing programs, new course sequences will be necessary to provide allied health workers with the additional training they will need for their roles in the reorganized health delivery system. In line with academic traditions several new curricula will be developed, one for each new allied health function. This method could create a whole new list of job categories in which there would be little room for advancement and no way out except a complete re-education. If the mold of tradition could be broken and more flexible programs provided, retraining, and upgrading would be more appealing and the academic institutions could better serve students and employers.

Upgrading and Training Opportunities for Employees of Health Care Facilities on the West Side

The purpose of this paper is to identify and evaluate problems of the upgrading and educational programs and to determine how accessible these programs are to the employees who work in the west side health care facilities.

The Importance of Upgrading and Education Opportunities in Health Care Facilities

The importance of upgrading and training opportunities originate from several sources: first, the impact of technology and the change in structure of health care facilities next, the changing sources of entry level workers, their education, skills, and attitudes. All of the west side health care facilities have been influenced by these changes in various ways.

Campbell and Tucker (68:2) state "...as the system of health care changes, so must the personnel...the education and training of these health personnel must change; and for the optimal efficiency and effectiveness, the training system itself must change."

In the same report they said that the impact of "...technology and less emphasis on acute infectious diseases and traumatic injuries to treatment and prevention of such conditions has changed the very essence of hospital care." they point out that the institutionalization of health care (because doctors do not have all of the complex theraputic machinery in their office) specialization, involvement in new disciplines both technical, social, environmental and behavioral has changed the structures and functions of health care facilities." Not only has the structure and the type of services delivered changed, but also the manpower pool from which entry level workers are drawn

has changed. As part of a continuing trend, the city's minority population has increased. Almost all of the west side health facilities are surrounded by minority communities, and most of the hospitals employ many of their entry level personnel from this communities. As stated in a paper presented at the American Hospital Association (Holloway 71:3). "Most of these people have only entry level skills. By "entry level" we mean those people who bring no marketable skills to the job and are typically employed in jobs with no opportunity for developing skills to enable them to advance in the organization. The kinds of jobs available to people who have no skills are usually found in the departments of nursing (nurse aide), dietary (dietary aide), and housekeeping (maid or porter). These jobs involve a variety of things from working directly with nurses and patients on the units, to mopping and sweeping floors, washing walls, or making salads. The hospital is faced with a high rate of turnover, absenteeism and tardiness among "entry level" employees. The jobs they hold are dead end, pay little, and are "dehumanizing."

In the understanding of the changing nature of health care delivery, the high morbidity and mortality in the lower socio-economic communities and the denial of opportunity for people who have been exploited, we hope our findings assist the hospitals and colleges in developing career mobility and upgrading opportunities for all of its employees.

We feel, as was eloquently scared by Malcolm Todd (70:565) "Basic to the concept of career mobility is the need to evaluate each individual's abilities, regardless of the route he traveled to obtain them.

The goal of such evaluation is to encourage the advancement of personnel up the career ladder to levels of responsibility commensurate with their knowledge and skill. Proficiency and equivalency examination serves as a basis for this evaluation." We want to improve the recruitment, education and productivity of medical personnel by encouraging health care facilities and colleges to work cooperatively with hospitals; we hope to bridge gaps in curricula, develop the usage of core curricula proficiency testing, and shared training programs.

The Focus of the Study

The primary focus of this study are the two general occupational areas in health care facilities which usually experience manpower problems, allied health and the entry level jobs. Technical jobs, which usually require 2 to 4 years of training and professional registration, includes medical record technician, laboratory technicians, X-ray technicians, and nurses, etc. (However, training for nurses was not considered in this paper because of the unusual training requirements). The entry level jobs are those which do not require any previous formal education of skills, and are usually found in the department of nursing (nurse aide), housekeeping (maid and porter), and dietary (dietary aide).

These areas continuously experience personnel shortages. The entry level positions are characterized by high attrition rates because of the low pay, unusual hours, and lack of advancement opportunities and the degrading nature of the work. The technical occupations experience manpower shortages, because of the waste and duplication in educational

programs designed to train such personnel; and the exclusion of disadvantaged people due to inflexible educational practices and the failure of the public educational system. (See the paper on education opportunities). Shortages are also due to the inability of employers to provide opportunities for their employees to gain the necessary skills, knowledge and credentials to fill the shortages in the technical areas. The other impediments, due to licensure, recruitment and education of technical personnel are more thoroughly discussed elsewhere. Nevertheless, one must understand that the forces of personnel supply and demand, coupled with shortage of technical (allied health) manpower, plays havoc with health care institutions with limited financial resources and critical technical personnel needs.

Procedure

Several questionnaries were constructed to examine the most relevant factors which are involved in upgrading and educational opportunities for the employees in the west side health care facilities. The questions were derived from concepts found in literature on allied health occupations, licensure laws, allied health curricula in various colleges, personnel profiles, policies and practices of the health care facilities.

Items for all of the questionnaires were developed over a two month period. The final drafts of the questionnaires were constructed by the two planning associates and approved by the senior planners.

Initial contact was made with the administrators of the health care facilities by phone. A short letter was then sent to the directors

of training programs in health care facilities, describing the project and summarizing of the type of information in which we were interested. Approximately three days later, these people were contacted by phone and were asked to meet with the planning associates for an interview.

The interview attempted to identify manpower shortage areas, upgrading opportunities, and effects of the poor economic conditions which existed during 1970 and 1971. At the interviews, the head administrator of the particular department was asked to have completed--by the most appropriate person--a questionnaire which assisted in a detail description of each of the active training programs.

Some Characteristics of the Sample

Out of the twenty-one primary health care facilities on the west side, there are two instances where two hospitals shared the same administration, personnel and training functions.

These four hospitals were counted as two and one small specialty hospital did not participate in the study. This reduced the number of institutions to eighteen. These institutions then were classified by size into categories of large, medium, and small, the two private hospitals who shared the same administration were counted as one and placed in the medium category although individually they would have qualified for the small group.

Upon collection of data it became evident that "upgrading opportunity" is closely associated with health facility bed capacity (size). Health facility size proved to be a reliable indicator of revenue and total resources of the hospital, therefore, health facility size

was used as the main control variable in the following tables.

Other variables which were associated with whether or not these health care facilities provided upgrading opportunity are: hospital goals (as determined by their governing boards); general economic conditions and how it affected hospital census and revenues; the availability of grants for training programs; personnel shortage areas within the hospitals and the demand from employees for upgrading programs.

Although the effects of all of these variables can not be measured except by complicated statistical indices, the instruments (see appendices for questionnaires) attempted to deal with the following:

1. training and personnel functions in health care facilities.
2. how training needs are determined.
3. how economic conditions have ffected health care facilities and their ability to provide upgrading opportunities.

Training and Personnel Functions in Health Care Facilities

The primary function of the personnel department in any business is the recruitment and evaluation of personnel. Training departments are designed to insure that the personnel are kept up to date in knowledge and skills. Most of the west side health care institutions lacked systematic written means of evaluation of employees. Even in the most progressive of the large institutions systematic written personnel evaluation was initiated as recently as July, 1972.

Frequently employee evaluation is conducted by immediate supervisors. When this arrangement is present, along with unsystematic and evaluation criteria, the employee often has no neutral person to

turn to when he is in conflict with his supervisor.

Valid personnel evaluation is important in assuring the optimal use of personnel and the highest standards of patient care. There is also a correlation between the size of health care facilities and systematic, codified evaluation policies. Larger hospitals have codified personnel procedures more frequently than small health care facilities. This may be a reflection of positive attitudes of hospital administrators, or financial resources to conduct such programs or, more likely, a greater need for more systematic procedures in a large complex bureaucracy.

The evaulation of individual personnel performance is important; but the evaluation of the total manpower effort is even more important. In order to insure the optimal care in the most cost effective way, health care facilities must examine medical records, admission records, morbidity patterns, employee mrale, employee turnover, and demographic data on the population they serve. Needs analysis should be the first step in identifying upgrading and training needs. Large hospitals often have the expertise, financial resources, personnel utilization data, patient care evaluation questionnaires (questionnaires distributed to discharged patients asking them to evaluate the services), to conduct a valid needs analysis.

In most hospitals the director of training functions is a resource person. He provides curricula, bibliographies and lesson plans, while

the immediate supervisor does all the actual training. Often, supervisors are primarily interested in production and frequently supervisors are more concerned with stability rather than mobility. Upgrading of lower staff may be perceived as an additional task that is not relevant to their main objectives, and may also place the supervisor in a new and threatening role.

The Effectives of Economic Trends Upgrading and Training Opportunities

The recent recession of 1969-1971 has effected upgrading and training opportunities by reducing hospital census and total hospital revenue, by reducing the amount of money consumers had available for hospital care, and bu reducing the amount of money available from governmental training grants. However, large hospitals, and hospital whose primary source of revenue are state, federal of local subsidies have not experienced adverse effects from the economic crisis. It is the small private hospital that has suffered. This is important because there are many small hospitals and they employ a significant portion of the health manpower, and they are frequently located in minority communities.

As the result of adverse economic conditions the small hospitals experience manpower shortages in the technical and entry level positions more often than other hospitals. In times of economic crisis, personnel is often the area in which the first cutbacks are made. The cost of labor is, in many cases, the greatest cost businesses incur, and often it is one of the most liquid of business assets.

Personnel Shortage Areas in West Side Hospitals 1972

Shortage areas or needs can be defined in several ways. First, the minimum number of personnel needed to deliver the optimal level of health care, secondly the number of budgeted unfilled vacancies.

As demon strated in Table One, the small and medium sized hospitals reported about the same number of total personnel shortages as the large hospitals. Nursing and allied health were the areas most frequently mentioned as personnel shortage areas. The area which is ranked behind nursing and allied health as being problematic to fill was clerical.

Table I

Personnel Shortages by Facility Size - West Side

Personnel Shortage Areas	Health Care Facilities			Total by Area
	Large	Medium	Small	
Administrative	-	-	-	-
Allied Health	3	1	2	6
Clerical	2	1	2	5
Dietary	-	1	1	2
Housekeeping	-	3	1	4
Laundry	-	-	-	-
Maintenance	-	-	-	-
Medical	-	-	-	-
Nursing	3	4	3	10
Nursing (Aid Level)	-	-	-	-
Social	-	-	-	-
Supervisory	-	-	1	1
No Response	1	-	-	1

Note that small and medicum sized hospitals reported housekeeping and dietary as being a difficult area to maintain personnel. These patterns help support the point about low wages, unpleasant work conditions and limited advancement opportunities in the entry level positions in small hospitals.

There is some indication that personnel needs are under-reported in small and medium hospitals. This is due to the realization they often can not find the personnel they need with salaries they are willing to pay. Consequently, they do not budget positions which they know they cannot fill.

In a questionnaire administered to nine (9) of the participating institutions five (5) small, two (2) medium and two (2) large, the response to the question "what is the most frequent reason for employee turnover was ranked as the following:

1. leave for another position
2. leave to further education
3. leave the city altogether
4. family responsibility (women with small children)
5. dismissed for cause of lay off due to lack of work
6. illness
7. poor work conditions and fringe benefits
8. dissatisfied in general

It is interesting to note that of the respondents' reason for employee turnover, "dismissed for cause" is listed fifth behind other reasons which indicate employee dissatisfication. This support the hypothesis that much of the entry level hospital work is intrinsically dissatisfying, and that unless these positions offer more financial reward or mobility, that tremendous money and energy will be expended in retaining personnel in these positions. Much of this money and energy can be channeled to the development of programs to train personnel for the other areas of personnel shortage. In the next section

we will attempt to measure the level of upgrading opportunity in the health care facilities in the west side sub-area.

Measures of Upgrading Opportunity

One good indicator or upgrading and training opportunities is the separation of training and personnel functions. Hospitals which have identified a need for training, or understand the value of it, often have a person or a unit solely responsible for this function. In Table Two one can see that there are almost twice as many large hospitals with separate training departments as compared to small and medium sized hospitals.

Table II

Health Care Facilities With Independent Training Unit

Facility Size	Training Unit	No Training Unit
Large	5	1
Medium	3	3
Small	3	*2
Total	11	6

* one small facility did not respond

A better indicator of upgrading and training opportunities is in the response to the question; "Do you provide any of the following for all employees who qualify and want to participate..."

a. Release time
b. Educational reimbursement
c. career ladder
d. none of the above

Most upgrading opportunities can be found in large hospitals; if one is an employee of a medium sized hospital one has a fifty-fifty chance of getting release time or reimbursement for job related education; and if one who works in a small hospital wants to advance through formal education, often, unfortunately the best way to do it is by discontinuing employment at the hospital.

Even when hospitals have training units they are often under-budgeted or understaffed. Methods of measuring the effectiveness of training must be developed, so that this important function is given proper place among the hospital's priorities.

The most important measure of upgrading opportunities is indicated by whether or not hospitals provide educational reimbursement or release time for their employees. These methods of encouraging employees to upgrade themselves are important because the cost of in-house education has risen tremendously in the last few years. Also, educational institutions can better provide general academic training that is required by the present health licensure laws.

The ideal method of assuring the optimal usage of personnel is through the development of career ladders. A career ladder is a system which includes a series of positions and training which leads to a skilled or technical career.

In Table III we can see the samepatterns, upgrading opportunities are more frequently found in the larger or government financed hospitals.

Table III

Health Care Facilities by Size and Types of Upgrading Opportunities

Facility Size	Release Time or Reimbursement & Career Ladder	Release Time & Reimbursement	No Release Time or Reimbursement
Large	1	4	1
Medium	0	3	3
Small	0	2	4
Total	1	8	8

Conclusion

Size and hospital income are the primary determinants of the availability of upgrading opportunities. Therefore, the smaller hospitals will have to either attempt to establish for their individual training programs or, develop cooperative realtionships with other hospitals and schools to meet their training needs.

The health care industry like other business must survive in a competitive environment. Since the health care industry is experiencing a rapid growth and change period, the individual hospitals must maintain their share of the labor market--in terms of well trained productive personnel-or perish.

The answer to the problem of health manpower maldistribution is complicated, but it appears to be obvious that a better usage of indigenous personnel through upgrading and training is a rational approach to the solution of this problem. Smaller hospitals and clinics will have to develop co-operative relationship with other hospitals and educational insitutions. The health consortia being developed in Springfield and Chicago appear to be a positive approach to the problem of training and upgrading hospital personnel.

Adminstrative Concerns for Academic Programs in Allied Health-Survey Report

Initial surveying completed by the manpower staff regarding the accessibility of allied health programs in academic insitituion to residents of the planning area raised several questions regarding the administrative perspective and the constraints on program planning and development. As a further effort in the evaluation of programs in academic institutions, the manpower staff developed a follow-up survey directed at the administrators of such programs.

Methodology

The survey itself was designed to be administered as a semi-structured interview. The form included several choices for answers to the questions. These choices served three functions: 1) to facilitiate note taking by the interviewer; 2) to serve as the responses expected by the staff based on previous study; and 3) to be presented to the respondant after his initial answer as a method of standardizing responses. Open ended questions were chosen by the staff as preferable to multiple choice so as not to limit or focus the responses of the administrators.

The survey concentrated on six areas of concern: 1) development and implementation of programs; 2) financing, 3) equivalency, testing, 4) student attrition, 5) accrediting, and 6) cooperative arrangements. Further questions were asked regarding student support services and evaluation of programs by students.

The survey was administered to five of the seven academic programs serving the west side. These programs were housed within the following institutions: two medical schools, one public and one private; two junior colleges, one public and one private; and one private university. Due to scheduling difficulties, one public junior college and one private university were not surveyed. Since similarities between institutions of the same level and similar financial base were revealed in the previous study, we will assume such similarities to be the case in this instance also.

Findings

Development and Implementation of Programs:

Contrary to the expectation of the staff, responses to questioning involving the rationale for initiating any particular program over another were most frequently related to market demands and manpower shortages. In every case, the administrator relied on outside sources for the provision of data to substantiate a need for a particular category of health professionals. The administrators also admitted that they relied heavily on studies they received in the mail and not on a formal review of statistics. It is interesting

to note that the universities also reported a consideration for whether or not the subject matter was suitable to college level instruction, while junior colleges reported consideration of the cost of implementation of the program.

In response to questions regarding the length of time necessary to get a new program or changes in an existing program approved, the institutions were clearly divided in terms of financial base. Private institutions at every level reported an approval time of one to three months. In these institutions the program administrators felt that they had the effective final authority to approve programming, i.e., approval of the president of the institutions was almost automatic and took very little time. In only one instance was a private institution reluctant to specify a three month maximum. This was due to the necessary approval of fiscal officers for allocation of funds, a process which in some cases could extend the approval process.

Public institutions, on the other hand, were confronted with the institutional hierarchy within the school itself and then with the bureaucracy of the state. Thus, they reported approval time as being no less than one calendar year. It would seem that the public institutional structure is for more formalized than the private.

In spite of this, the only suggestion from the group to improve the approval process was to create an advisory committee whose function would be to evaluate the need for programs in terms of availability of jobs for the graduates.

Only one institution reported difficulty in finding instructors. This administrator differentiated between people with credentials and people who can teach effectively. It was his contention that while there are many of the former, the latter category, those willing to make the extra effort required of a good teacher, were rare. Lack of difficulty finding instructors was attributed to: the innovation of the program, the opportunity for the instructor to express his creativity, and the general overflow of paramedical professionals in the job market.

One problem of interest pointed out in the implementation of allied health programs in academic institutions is the reconciliation of administrative policy with accrediting standards. It seems that outside the medical school settings, administrative policy dictates the number of contact hours between teacher and students at substantially less than the contact hours required by accrediting agencies. Thus teachers in this situation must be willing to donate the extra time required to maintain accredited status.

Financing:

Initial costs in implementing allied health programs are prohibitive due to the high cost of equipment for labs. However, beyond that, the greatest portion of the money used in allied health programs is spent for teacher salaries. Every institution, including the private medical school, reported receiving state funds. Some federal

funding was reported, as was private fund raising.

In response to questions about the cost of clinical affiliations most administrators responded that the tight money situation had had no effect on their clinical affiliations. One respondent reported that some hospitals had begun to require payment for the service of providing placements. Another administrator reported that hospitals had been charging for clinical affiliations for students, but that these were formal tuitions and students were generally awarded scholarships to cover this expense.

Equivalency Testing:

Four of the five institutions made use of equivalency tests. These tests are almost always objective, paper and pencil tests. Some of the tests are standardized, however, most allied health occupations are not covered by the standardized test. One institution reported that their program would fashion a test on its own for students who felt they could pass a course on their prior knowledge. All the institutions reporting the use of equivalency exams were satisfied with their effectiveness.

One institution reported that they did not use equivalency tests, but that they were developing policy around the issue.

Student Attrition:

Generally, the institutions surveyed reported remarkably low attrition rates. The largest rate specified was 12%. All programs reported that the student drop-out rate for the allied health programs was lower than the drop-out rate of other programs in the institution or than that of the institution itself overall. One administrator supposed that students entering the allied health progams are generally more serious students. Thus, these students are not inclined to drop-out because they have changed their career orientation and are apt to put greater effort into their studies and less likely to fail. Another administrator cited a thorough pre-counselling program, which helps screen out students who are not really interested in the health field or are uncertain of which profession they truly are interested in, as a factor in the low attrition rate.

The most frequent reason reported for student attrition is personal reasons or family responsibility. Two institutions reported failures as reasons for attrition. Only one institution reported disinterest or change of career goals as a reason for attrition.

There was one instance in which the administrator reported a minimal increase in the cost of running the program due to attrition. Other institutions reported that attrition had no effect on cost.

Accrediting:

In every case, administrators stated that special accreditation for allied health programs was not required by the institution. Overall accrediting for the college or university as a whole covered all programs conducted as a part of the college or university. The dominant reason given for special accreditation was that such accrediting was a service to the students in the program. In order to sit for certain certification of licensure exams or to be listed on national registries, the student must be a graduate of an approved program, i.e., one which is nationally accredited. The accreditation adds status to the students' credentials also. Thus, it is in the best interest of the student to accredit the programs. The force of this desire to provide a "service to the students" is best expressed by one administrator who described accrediting as a "moral obligation."

Most administrators, however, were unwilling to allow the suggestion that the accrediting process affected the quality of their programs. One administrator stated that his programs were in existence before the accrediting agencies, and that the accrediting requirements developed matched their program standards accurately. Other administrators contended that their programs were not developed to meet requirements for accreditation and in fact offered more than was required. Only one administrator saw accrediting standards as a guideline for what students should learn. Other reasons stated for accrediting included: the additional status accreditation gives a program, attraction of instructors to accredited rather than non-accredited programs, and assurance of quality in accredited programming.

Although assurance of quality was stated as a reason for accrediting programs the administrators raised serious questions about whether the process actually met this goal. In fact, there was skepticism expressed generally about the ability of the accrediting process to fulfill its goals. It was generally agreed that taken nationally, the accrediting process does standardize curricula at least in terms of providing minimum standards. However, beyond that minimum, curricula in any subject area vary considerably.

There was strong feeling among some administrators that the accreditation process as currently carried out serves the purpose of furthering professionalism. This feeling ranged from the idea that accrediting implemented a "closed shop" policy in the professions to the idea that the whole process amounted to "game playing". If the purpose of accrediting was stated as the maintenance of political control over the development of the professions within the professions themselves and the promotion of professional elitism, several of the admininstrators would have agreed without reservation that the process served its purpose.

The administrators also were concerned with the process of accreditation. They generally agreed that the process was time consuming in terms of paper work and sometimes slow. There was also concern for the infrequent surveys and site visits after initial accrediting is granted and for the procedure for initial accreditation.

In spite of their complaints and skepticism, the administrators agreed that some sort of accrediting was necessary. They suggested that since inadequate staff was the cause of the infrequent site visits, annual or bi-annual self surveys could be instituted as a method of assuring the continued compliance with program standards. Alleviation of the problems of receiving accreditation initially could be accomplished through the implementation of a milder provisional accreditation until the program has been fully evaluated.

Other suggestions for improving the process had to do with the administrators concern over the use of the accrediting process to maintain political control and promote professional elitism. A revision of the state licensing laws to give more flexibility or at least more liberal interpretations of existing laws was seen as necessary, i.e., the laws should be written and interpreted to include people into rather than keep people out of health professions. Further, establishment of a national accrediting body for all occupations was suggested. This new agency should be educationally based and should include representation from each of the various professions.

Cooperative Arrangements:

Of the institutions surveyed only one did not report any type of cooperative arrangements aside from clinical affiliations to provide practical training for the students. Of the arrangements existing in other institutions, there are two instances of sharing of instructors, two of sharing of laboratory facilities, and one instance of a shared library.

Sharing of facilities was the most readily acceptable form of cooperation discussed with administrators. Libraries and laboratory facilities were seen as expensive to set up and maintain and the cost benefits from such sharing could be immediately appreciated. One administrator even suggested the possibility of shared parking facilities for institutions in close proximity.

In most instances, however, other forms of cooperative arrangements were viewed with skepticism. Some administrators expressed a concern for draining their own resources or overburdening their staff. The prevailing opinion seemed to be that sharing meant one institution would of necessity be giving up something to another without return. Shared instructors and classes were particularly viewed in this manner.

The idea of consortium arrangements was largely unthought of among the administrators, not because they were unfamiliar with the idea, but because they had given the idea no consideration in terms of their own program. Only one institution was involved in a consortium arrangement and that was with another institution from outside that state. Explaining the idea of consortium as an arrangement of mutual benefit did little to allay fears of diluting existing programs.

In spite of the skepticism regarding consortial arrangements, none of the administrators could foresee any policy problems in initiating such an affiliation. From the list of administrative details to be negotiated in consortial arrangements, only one administrator saw a problem, that problem being transportation between institutions. Interestingly, transportation was not seen as a problem by the one administrator involved in a consortial arrangement. The only problem identified with implementing consortia was stated by one administrator as attitudinal. This administrator cited the overcoming of institutional autonomy, i.e., the attitude within institutions that they own their programs and must implement them alone.

Another administrator expressed concern over the idea of limiting the schools from which programs could accept entering students though consortial arrangements. This administrator objected to the idea of universities and medical schools formulating agreements with specified junior colleges or high schools only to accept their graduates. The objection was based on the ground that the student should have the right to apply and be considered at the institution of his choice on equal basis with all other applicants regardless of where he received previous training and the right of institutions to accept any qualified student.

The final question regarding consortial arrangements concerned the initiation of consortia to include both schools and hospitals to reduce duplication of programs and resources. This question asked what type of institution or agency should initiate discussion of such an arrangement. It is interesting to note that only one administrator responded to the question as asked. His suggestion was the Chicago Hospital Council, because that agency could serve as a neutral party in discussions. Other administrators resisted the idea of such a consortium as currently unfeasible but mainly as a drain on existing program resources.

Conclusion:

The format and methodology of this survey were quite effective in accomplishing the objectives of the effort. Much valuable information was collected in conversation revolving around the questions which

would not have come out in a self-administered survey or in a more structured interview. However, in many cases time constraints prevented as much detail on some questions, especially the final ones regarding consortium. This led the staff to believe that the survey may have been too long to conduct in one session. Scheduling two sessions with each administrator might also have been difficult.

The survey results bear out a need for reducing program cost. Each administrator cited expenses as a problem in one form or another. Yet the resistance to cooperative arrangements with other institutions precludes any immediate action in this regard to alleviate cost problems. The staff, therefore, can only conclude that more exposure to the idea of cooperative arrangments especially their cost benefits must precede any attempt to initiate cooperative programming.

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"Training the Health Worker" - Conference Report

Background and Purpose

The health worker is one whose effective training must be a carefully coordinated mixture of clinical and academic experiences. He should not only be competent in performing his own particular function, but he must also understand his position in the overall system of health care delivery.

Health care facilities and academic institutions are faced with the task of providing such workers. Further, they must accomplish the education and training of such workers within the context of a rapidly growing and changing field. Thus they must prepare a worker, who is competent in today's skills and who can keep abreast of the expanding knowledge, developing skills, and changing role of his occupation.

Traditionally, hospitals have provided clinical placements for students in academic institutions, and whatever additional training was required by employed personnel was provided by the hospital. Training for employed personnel was generally minimal and confined to skills upgrading. However, new trends in licensure regulations requiring evidence of continuing education as well as updating of skills by the health worker reflect a recognition of the continually changing demands on the various health prefessions. Continuing education for persons currently employed in the health field demand close coordination of academic programs with the health facility. Changing patterns in the roles of health care personnel require concomitant changes in academic curricula to prepare efficient new health workers and to reorient those currently employed. These developing attitudes require a closer coordination of academic and hospital training and a further responsibility of academic institutions to provide short term curricula to meet the continuing education requirements.

Studies conducted by the manpower staff of training opportunities in the planning area slow several programs offered in both hospitals and schools in the various allied health fields. However, admission policies of academic institutions are generally geared toward the "typical" college student, i.e., one sho has just graduated from high school, is still supported by his parents, and has no real responsibilities other than continuing his education. This orientation not only forms an effective deterrent to the participation of residents of the planning area in these programs, but also hinders coordination with health care facilities for programming to upgrade currently employed personnel. (See paper on accessibility of training in academic institutions).

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Participants and Methodology

Comparisons of studies of training in both hospitals and schools reveal that both efforts are conducted within parallel constraints and must overcome similar problems. With similar problems and constraints and common goals, the manpower staff could only conclude that in light of trends in health education closer cooperation between the two types of institutions was necessary to alleviate the situation. The staff, therefore, proposed to hold a conference which would bring together representatives from academic institutions and health care facilities to consider their common problems in the hope of gaining insights toward their solution.

A conference concept was drawn up by the manpower staff outlining the purpose, proposed participants, and topics of common interest identified by the staff. This concept was presented to a resource committee called together for the purpose of reviewing the conference plans. The committee membership was proposed to involve representation from smaller hospitals, larger hospitals, independent health clinics, academic institutions and agencies. The participants on the committee included representatives from a neighborhood health clinic, a junior college, a university and three agency representatives plus staff.

The committee favored the idea for the conference and approved the design and concept with some changes. The major concern of the committee regarded implications that the conference would have for future activity. It was generally agreed that having a conference just to discuss issues was not enough. Aside from a determination that the conference focus on concrete issues and practical rather than theoretical problems, there was a concern that the conference have as result some assurance that something would be done with the decisions and recommendations made, i.e., that the conference the beginning step in an ongoing process. Thus, a general agreement was reached that the conference take on a two-fold purpose:

1. the stated purpose of addressing training health manpower and culminating a year long CHP-WSHPO manpower project and,

2. to begin a new phase of actively promoting cooperative efforts between institutions in this regard.

(see attached minutes of the resource committee meeting.)

Malcolm X College, a community college serving the planning area, through its Department of Allied Health Sciences agreed to co-sponsor and host the conference. The assistant dean of the college worked closely with the planning, initially as part of the resource committee and then as co-sponsor. The college provided its facilities as a site for the conference and the back up services of its print shop and cafeteria as well.

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The conference format included a keynote address to provide background and focus for the workshops. Five workshops constituted the care of the conference. Each workshop considered a particular issue and problem of training. (See attached conference concept). The format of the workshops provided for a discussion paper to be presented on the topic by someone working in that particular area. Two responses were presented to each discussion paper by representatives of academic institutions, health care facilities, or agencies. Care was taken to assure that the two respondents represented different types of agencies. Questions and discussion from the floor revolved around these presentations.

One workshop, "Financing Health Education", deviated from the standard format. Due to the great difficulty experienced in recruiting someone to present a discussion paper, the presentation format presented in this workshop was changed to a panel. The four member panel was made up of a hospital administrator, a vice chancellor from the Chicago City Colleges, and two agency representatives.

Participants at the conference were invited from deans and faculties of health education programs in academic insitutions, administrators and personnel and training directors of health care facilities, and agencies and interested people concerned with the training of health manpower. The conference was sponsored by and part of a project for the west side sub area of Chicago, and the list of participants began with institutions and agencies serving the west side planning area. However, the staff recognized the inter-institutional relationships already established in terms of affiliations between academic institutions and affiliations between schools and hospitals for clinical placements. These affiliations cross any and all arbitrary boundaries and extend across the entire metropolitan area. Further, residents of the west side planning area work in, go to school, and are served by any of the institutions in the city. Agency affiliations are similarly unrestricted. The decision was made therefore to invite participation from institutions all over the city of Chicago, especially those with existing affiliations with institutions physically located on the west side.

Results and Conclusions

The conference was held as planned with a broad cross-section of the agencies and institutions invited attending. The participants consisted principally of deans, department heads, and staffs from academic institutions, training staff from hospitals and agency representatives. Some staff members of neighborhood health clinics also attended. However, aside from invited speakers, no hospital administrators attended. While all areas of the city were represented, the majority of the participants were employed in institutions serving

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the west side of Chicago, The attendants were divided almost evenly between health facility, academic institution, and agency personnel. Thus the conference did attract the targeted population.

There was general agreement among speakers participants and the manpower staff that the workshops did provide meaningful discussion. However, no specific recommendations come from the workshops. Instead, the workshops were used as idea exchanges, and original purpose identified by the staff but broadened in response to suggestions by the resource committee. This was perhaps due in part to the variety of agencies and positions represented by the participants, and perhaps also because the participants were not at liberty to commit their institutions without clearance from their administrative officials. (As noted above no administrators attended although they were invited.) The desire of the resource committee for a group to be elected from the participants to implement recommendations was also not realized, perhaps for the same reasons.

Fulfillment of the second purpose of the conference, that of initiating further activity, was recognized by the staff as important. To make up for the lack of specific recommendations for future activity, a conference evaluation form was developled by the staff and distributed to the participants. Hopefully, the return of the forms will indicate areas of specific concern for the participants and indicate areas in which meaningful activity can take place.

Although the conference was generally considered successful, more extensive utilization of the resource committee and an opportunity for all of the speakers to meet with the staff and the committee could possibly have facilitated the realization of all the goals of the conference. Such a meeting could have encouraged the speakers to direct workshop discussions toward recommendations and an implementation mechanism. Without this mechanism, it is incumbent on the staff to recruit participants in any implementation activity. While such recruitment is possible, it will be necessary to make clear that any implementation is a direct result of the conference and not another activity with no relationship to it. Further, such recruitment runs the risk of formulating yet another committee of persons already active in projects regarding the training and utilization of health manpower, and not reaching those conference participants who are not yet so involved.

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Proposed Joint Hospital Training Program

Background and Purpose

The west side planning area includes within its boundaries 18 hospitals and some 70 or more clinics. Of the hospitals, 6 are considered large (300 beds or more), 6 are medium sized (100 to 200 beds) and 6 are smaller (100 beds or less). The area also contains several universities and colleges with medical schools, nursing schools and schools of allied health.

A majority of the residents in the planning area are persons of minority racial or ethnic groups, most of them black. They are economically and educationally disadvantaged and are victims of the poor quality services and deteriorated physical surroundings characteristic of ghettoes in the inner city.

The combination of the poor quality education offered in overcrowded inner city schools and low income, which denies access to better education, leaves the residents of the west side planning area minimal skills to qualify for existing job openings. They are hired in positions at the lower levels of the pay scale, and without the opportunity to upgrade their skills, they find themselves in "dead end" jobs.

Studies completed by the manpower planning staff indicate a serious lack of systematic programs for upgrading personnel in the hospitals in the area (see paper on upgrading opportunities in health care facilities). Further, surveys conducted by staff into health manpower utilization and attrition in west side hospitals indicate that of the most frequent reasons for attrition reported by hospitals, "leave to take another position" ranks highest on the list. The second most frequent reported reason for attrition was "leave to further education". (N.B. The question on the attrition survey was an open ended one: "In your opinion what is the chief cause or causes of employee turnover in para-professional positions") In a ranking of reported reasons for attrition "dismissed for cause" or "lay off due to lack of work", which would denote dissatisfaction of the employer, ranks fifth behind reasons which all indicate dissatisfaction of the employee. Of the total of eight reasons ranked, only two indicated employer dissatisfaction; these two ranked fifth and eighth.

These findings lead to the conclusion that the existence of opportunities for self-improvement and advancement within the hospital structure would reduce the high turnover rate in the lower ranking job categories. However, informal interviews and conversations with hospital administrators and directors of personnel and training point to an inability of hospitals, especially smaller hospitals, to provide such opportunities. This inability can be attributed to the insecure

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financial situation of the smaller hospitals and their lack of staff to conduct such training efforts. In fact, hospitals reported difficulties even in completing surveys regarding attrition due to insufficient staff.

Participants and Methodology

In light of this situation, the West Side Health Planning Organization proposed a joint training effort to be undertaken by five of the health care facilities in the planning area. Participating hospitals were those willing to take part in such an effort and included, one large public hospital, two medium and one small general hospital and one neighborhood health clinic. All of the participating institutions recognized an identifiable need for training and expressed a willingness to give the joint effort some consideration.

An initial meeting was held with representatives of the five health care facilities, i.e., directors of personnel and where possible directors of training, and the manpower staff to discuss the possibilities for the program. The concept was explained and the rationale put forth that the joint effort would save each hospital money, hopefully by reducing employee turnover and by reducing the cost of training by participanting in a joint effort. The staff had also identified the Chicago Model Cities Program as a possible funding source.

There was one resistance to the idea that Model Cities money could only be used to train residents of the Model Cities Target Area. It was determined, therefore, to identify another, less restrictive source of funds. The representatives were also hesitant to commit their respective institutions to guarantee upgraded positions for the employees after training. There was some discussion of areas in the hospital or clinic in need of training. The meeting closed with a commitment on the part of those in attendance to investigate upgrading possibilities with their administrators, determine areas in need of training, and identify employees who could be trained.

After a series of phone calls and a second meeting, two areas for training were agreed upon: clerical and General Education Development, high school equivalency. The decision was made to identify potential trainees in each hospital and to discuss with the administrators release time policy in those institutions with no stated policy. The manpower staff would investigate the resources for instruction.

Follow-up calls were once again made. As a result of the increased clarification of the scope and extent of the project, three of the hospitals were constrained not to participate further at that time.

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This left the large public hospital, the medium sized general hospital and the neighborhood health clinic participating. The public hospital representative acted in this group as a consultant since his institution is one of the few in the planning area facilities with an extensive training program. In effect, therefore, only the health clinic and the medium sized hospital were left as participants in the actual training effort.

In each facility potential trainees were identified and classified by last grade level of schooling completed. In the hospital 64 persons were identified as needing a GED, in the clinic 13 such persons were identified. There were 12 persons in the hospital and 9 in the clinic in need of clerical training. The hospital was most desirous of providing clerical training to meet an immediate need. Since upgraded positons could not be guaranteed in the clinic, it was agreed to begin the effort with the GED program and postponed the clerical effort until later.

The Chicago Study Skills Center was identified as a resource for instruction. The Center provides instructors at no charge. The Center conducts an open-ended, open exit GED program and requires a class of at least 25.

A 20 week program was agreed upon. It was felt that in terms of hospital release time policy an open-ended program would be more than the administrator's would approve. Classes would be conducted two hours per day twice weekly. Because both facilities had classroom space available, division of classes between facilities was agreed upon. With half the program conducted at one site and one half conducted at the other neigher facility would have to absorb the entire cost of extra release time for travel. A proposal was to be developed by the manpower staff to be presented to the group for approval.

Shortly after this meeting, circumstances surrounding the reorganization of the health clinic precluded its further involvement in the project. With this development, the remaining hospital decided to re-focus their training efforts to their originally stated needs in the clericla area through their own training mechanism. The project was discontinued.

Conclusions

Several difficulties arose in the coordination of the project all of which were overcome. The restrictions placed on the project by the Model Cities program raised questions of fairness to all employees and employee morale, since training could only be offered to residents of that target area. However, this was overcome by deciding to seek funds from a different source. The anticipated problems of release time was worked out internally by the directors of personnel. The

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choice of areas in which to train was alleviated by a process of accommodation.

The only insurmountable problem in the project was the reluctance of administrators. Perhaps this was due to a failure on the part of manpower staff to offically involve the administrators in a meeting to explain the rationale for the project. In any future effort of this sort, we would recommend a presentation of available data to administrators designed to support the idea of training and upgrading as more than just a goodwill effort on the part of the hospital. A demonstration first, that training and upgrading benefits the hospital through increased production, improved employee morale and reduced attrition and second, that joint training is the least expensive method, would probably encourage administrators to be more enthusiastic in their support of such efforts.